THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO: 453-04-6385.M5

MDR Tracking Number: M5-04-0470-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 10-14-03.

The IRO reviewed therapeutic exercises, office visits, physical performance test and conductive paste or gel rendered from 04-30-03 through 07-15-03 that was denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the requestor **did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 01-05-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
4-30-03	97750-MT	$43.00 (1 unit)	$0.00	G	$43.00	96 MFG MEDICINE GR (I)(11)(E)(3)	G – Not global to any other service billed on this date. Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $43.00
5-21-03	95851	$36.00 (1 unit)	$0.00	NO EOB	$36.00	Rule 13.307 (g)(3) (A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $36.00
6-4-03	95851	$36.00 (1 unit)	$0.00	G	$36.00	96 MFG MEDICINE GR (I)(11)(E)(4)	G- Not global to any other service billed on this date. Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $36.00

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
6-6-03	99080	$12.50 (1 unit)	$0.00	N	$15.00	Rule 133.106(f)	Requestor did not submit relevant information to meet documentation criteria. No reimbursement recommended.
TOTAL		$127.50	$0.00				The requestor is entitled to reimbursement in the amount of $115.00

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 04-30-03 through 06-06-03 in this dispute.

This Findings and Decision and Order are hereby issued this 10th day of May 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

December 30, 2003

Re: IRO Case # M5-04-0470-01 amended 5/1/04

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic, who is licensed by the State of Texas, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient injured her back in ___ while lifting bags of clothes over her head on a repetitive basis. She began treatment with the treating D.C. on 1/23/03. An MRI and CT scan were performed, as well as a physical performance test and muscle testing. The patient was treated with therapeutic exercises and physical therapy.

Requested Service(s)
Therapeutic exercises, office visits, conductive gel or paste, physical performance test 4/30/03-7/15/03

Decision
I agree with the carrier's decision to deny the requested treatment.

Rational
The patient had extensive chiropractic treatment since her initial visit on 1/23/03 without documented relief of symptoms or improved function. A medical report on 5/27/03 noted that the patient still complained of back pain, decreased ranges of motion and muscle spasms. This was five months after treatment started with the treating D.C. A 6/12/03 report stated, "there is stiffness and weakness and she states her pain as a level 8, on a scale of 8 to 10, with 10 being the highest level of pain." The report also noted that the patient "is deconditioned and overweight." How could the patient be in this physical condition after months of intensive chiropractic treatment and rehabilitation? It is probable that care was inappropriate.
Upon finding an extradural mass on the 2/17/03 MRI the patient should have been referred to an orthopedist, neurologist or neurosurgeon for further evaluation, and chiropractic treatment should have been terminated and would have been contraindicated at that time. The patient had received a fair trial of chiropractic treatment with poor results prior to the dates in dispute. The continued use of failed conservative therapy modalities was not necessary.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.